INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Introduction to the IHCP

LIBRARY REFERENCE NUMBER: PROMOD00001
PUBLISHED: NOVEMBER 5, 2019
POLICIES AND PROCEDURES AS OF AUGUST 1, 2019
VERSION: 4.0

Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of August 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: February 13, 2017	Scheduled update	FSSA and HPE
2.0	Policies and procedures as of June 1, 2017 Published: January 23, 2018	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of October 1, 2018 Published: January 29, 2019	Scheduled update	FSSA and DXC
4.0	Policies and procedures as of August 1, 2019 Published: November 5, 2019	Scheduled update: • Edited text as needed for clarity • Removed the mailing option for Written Correspondence • Added notes regarding the change in FFS PA contractor • Updated the *Fee-for-Service* section, including adding information about Southeastrans • Corrected the frequency for Fee Schedule updates in the *Provider Reimbursement Methodologies* section • Added information about Southeastrans in the *Contractors* section • Updated the list of specialties that require ISDH certification and added information about CLIA certification in the *Indiana State Department of Health* section • Updated website information in the *Provider Relations* section and added a note about the IHCP Listens mailbox • Added EDI/Portal technical assistance for the Customer Assistance line in *Table 2 – Provider Resources*	FSSA and DXC

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Overview

Indiana's Medicaid program, collectively referred to as the Indiana Health Coverage Programs (IHCP), provides a healthcare safety net for low-income children and adults, including those who are aged, disabled, blind, pregnant, or meet other eligibility requirements. The IHCP receives federal and State funds to operate the program and reimburse providers for reasonable and necessary medical care for eligible members. Each state administers its own Medicaid program within the provisions of federal legislation and broad federal guidelines issued by the Centers for Medicare & Medicaid Services (CMS). The Indiana Family and Social Services Administration (FSSA) administers the IHCP.

Information on IHCP services is available in the *Indiana Code* (IC) and *Indiana Administrative Code* (IAC), which are published online at in.gov. The administrative rules for the IHCP, including but not limited to member eligibility, provider types, and covered services, are published in Titles 405 and 407 of the IAC.

The *IHCP Provider Reference Modules* can be used as a reference for medical coverage, billing guidance, and reimbursement policy for providers conducting business with the IHCP. Modules include instructions for submitting IHCP claims and prior authorization (PA) requests, as well as other related topics. All modules can be accessed on the *IHCP Provider Reference Modules* page of the IHCP provider website at in.gov/medicaid/providers.

Additional resources on the website include:

- *IHCP Banner Pages*
- *IHCP Bulletins*
- News and announcements
- Fee schedules (professional and outpatient)
- Code tables
- Provider enrollment and profile maintenance packets
- Program descriptions
- Contact information
- Provider education opportunities
- Forms, including prior authorization request forms
- IHCP Provider Healthcare Portal (Portal)
- Electronic data interchange (EDI) information, including *IHCP Companion Guides* for *Health Insurance Portability and Accountability Act* (HIPAA) version 5010

Delivery Systems

The following sections describe the delivery systems the IHCP uses for administering Medicaid benefits and healthcare. For information about specific IHCP programs and associated benefit plans, see the *Member Eligibility and Benefit Coverage* module.

Fee-for-Service

The fee-for-service (FFS) delivery system reimburses providers on a per-service basis. For services rendered under the FFS delivery system, providers should submit claims and, if required, PA requests to the appropriate IHCP FFS contractor, as listed in Table 1. The table also lists the provider reference modules that contain FFS billing and PA procedures for each type of service.

Table 1 – Fee-for-Service PA and Claim Submission

Type of Service	Submit Claims To	Submit PA Requests To	Modules with More Information
Pharmacy	OptumRx	OptumRx	*Pharmacy Services*
Nonemergency medical transportation (NEMT) services *(except services exempt from brokerage)*	Southeastrans	Southeastrans	*Transportation Services*
All others	DXC Technology	Cooperative Managed Care Services (CMCS)*	*Claim Submission and Processing* *Prior Authorization*
**Note: As of November 1, 2019, FFS PA requests will be submitted to DXC Technology instead of CMCS.*			

Managed Care

The State has mandated a managed care delivery system for members enrolled in the following programs:

- Healthy Indiana Plan (HIP)
- Hoosier Care Connect
- Hoosier Healthwise

Under the managed care system, members are enrolled with a managed care entity (MCE), which is responsible for the members' healthcare services. Each MCE maintains its own provider network, provider services unit, and member services unit.

Per the IHCP contract, the MCE is responsible for performing claim processing, PA authorization, and subrogation activities for its particular subcontractor network. The MCE with which the member is enrolled should be contacted for specific billing, PA, and reimbursement policies and guidelines as the MCE may have different requirements. Providers can find a member's assigned MCE by checking the member's eligibility in the IHCP Portal or through the Interactive Voice Response (IVR) system. For MCE contact information, see the *IHCP Quick Reference Guide*, available at in.gov/medicaid/providers.

All providers wanting to offer services to HIP, Hoosier Care Connect, or Hoosier Healthwise members must first enroll with the IHCP prior to contracting with the MCEs. Providers rendering services to a member enrolled with an MCE must be contracted with the MCE assigned to the member. This provision also includes out-of-state providers. See the *Provider Enrollment* module for details.

> *Note: The IHCP also provides the Program of All-Inclusive Care for the Elderly (PACE) for individuals 55 years old or older who are certified by the State to need a nursing facility level of care, are able to live safely in the community at the time of enrollment, and reside in a PACE service area. Designated PACE organizations serve as MCEs for PACE members. For more information, see the Member Eligibility and Benefit Coverage module and the Program of All-Inclusive Care for the Elderly page at in.gov/fssa.*

Managed Care Service Carve-Outs

The MCE is responsible for the delivery and payment of most care for its members; however, certain services are not paid by the MCE. These services, referred to as *carved-out services*, are billed for reimbursement as FFS claims. PA for carved-out services, when required, also follows the FFS process. MCEs must provide care coordination and associated services related to carved-out services, including but not limited to transportation.

See the *Member Eligibility and Benefit Coverage* module for more information, including a list of carved-out services.

Self-Referral Services

Most services in managed care require referral from a primary medical provider (PMP). Self-referral services are an exception. For services designated as *self-referral*, MCEs reimburse IHCP-enrolled providers without a PMP referral. Self-referral services must be covered under the member's benefit plan and established benefit limits, and PA requirements apply.

For more information, including a list of self-referral services, see the *Member Eligibility and Benefit Coverage* module.

Provider Reimbursement Methodologies

The FFS claim-pricing process calculates the IHCP-allowed amount for claims based on claim type and defined pricing methodologies for each provider type. These pricing methodologies include some of the following:

- Cost-based and case-mix reimbursement
- Diagnosis-related group (DRG)
- Fee Schedule
- Manually priced
- Medicare and Medicare Replacement Plan, and IHCP crossover coinsurance and deductible
- Outpatient ambulatory surgical center (ASC) flat rate
- Resource-based relative value scale (RBRVS)

Details about these reimbursement methodologies are found in *405 IAC 1-8* through *405 IAC 1-11.5*. For reimbursement information related to specific provider types and services, see the appropriate provider reference module.

Two fee schedules are available from the *IHCP Fee Schedules* page at in.gov/medicaid/providers:

- The Professional Fee Schedule contains a list of IHCP-covered Current Procedural Terminology (CPT®[1]) codes, Healthcare Common Procedure Coding System (HCPCS), and Current Dental Terminology (CDT®[2]) codes and includes indicators specific to each code, such as program coverage, reimbursement, and prior authorization. The Professional Fee Schedule is searchable by keyword or code and can also be downloaded free of charge. The IHCP automatically updates the Professional Fee Schedule each week.
- The Outpatient Fee Schedule reflects coverage, pricing, and reimbursement methodology for HCPCS and CPT codes billed by outpatient hospitals and ASCs. The Outpatient Fee Schedule is posted as a Microsoft Excel document (compatible with versions 97 or later) so providers can search and sort as needed. It is updated monthly to reflect any change in policies.

[1] *CPT copyright 2019 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

[2] *CDT copyright 2019 American Dental Association. All rights reserved.*

> *Note: Under managed care, the MCEs reimburse in-network providers as stated in their provider contracts, which may include negotiated rates. In the absence of another arrangement, MCEs reimburse out-of-network providers according to FFS pricing methodologies. Providers should contact the MCE for managed care program reimbursement rates.*
>
> *For additional information about managed care reimbursement, contact the member's MCE. See the IHCP Quick Reference Guide, available at in.gov/medicaid/providers, for contact information.*

State, Regional, and Contractor Responsibilities

This section outlines the responsibilities of the entities involved in administering the IHCP.

Family and Social Services Administration

The FSSA is the State agency responsible for administration of the IHCP, which requires coordination with a number of entities. This section outlines the primary agencies involved in program administration.

Office of Medicaid Policy and Planning

The FSSA Office of Medicaid Policy and Planning (OMPP) is responsible for the general planning and oversight of the IHCP, including coordination with program partners and contractors. The OMPP oversees the Medicaid State Plan, Medicaid waivers, and federal reporting. In addition, the OMPP establishes IHCP policy and manages IHCP contractor relationships.

Division of Family Resources

The FSSA Division of Family Resources (DFR) is responsible for determining eligibility for IHCP members, enrolling members in the appropriate program, and maintaining the eligibility files for the IHCP member population. A complete directory of local DFR offices is available on the FSSA website at in.gov/fssa.

Division of Aging

The FSSA Division of Aging is responsible for overseeing two 1915(c) Home and Community-Based Services (HCBS) waiver programs:

- Aged and Disabled (A&D) Waiver
- Traumatic Brain Injury (TBI) Waiver

The Division of Aging is also responsible for administering the Money Follows the Person (MFP) demonstration grant and processing Preadmission Screening and Resident Review (PASRR) requests.

Division of Disability and Rehabilitative Services

The FSSA Division of Disability and Rehabilitative Services (DDRS) manages the delivery of services to children and adults with intellectual and developmental disabilities. The DDRS administers two 1915(c) HCBS waiver programs:

- Family Supports Waiver (FSW)
- Community Integration and Habilitation (CIH) Waiver

Division of Mental Health and Addiction

The FSSA Division of Mental Health and Addiction (DMHA) administers three 1915(i) State Plan HCBS programs:

- Adult Mental Health and Habilitation (AMHH)
- Behavioral and Primary Healthcare Coordination (BPHC)
- Child Mental Health Wraparound (CMHW)

Contractors

The FSSA contracts with a fiscal agent and other entities to perform the day-to-day program functions associated with administration of the IHCP. Current contractors and responsibilities include the following:

- DXC Technology – Fiscal agent
  - Fee-for-service (FFS) nonpharmacy claim processing
  - Member and provider customer service
  - Provider enrollment
  - Provider relations
  - Managed care entity and enrollment broker support
  - Third-party liability
  - IHCP Provider Healthcare Portal

> *Note: DXC Technology will assume FFS nonpharmacy prior authorization and utilization review responsibilities, beginning November 1, 2019. Prior to that date, these functions were the responsibility of Cooperative Managed Care Services (CMCS), in its role as the FFS PA administrator.*

- OptumRx – FFS pharmacy benefit manager (PBM)
  - FFS pharmacy claim processing
  - FFS pharmacy-related prior authorizations
  - FFS pharmacy-related member and provider support
  - FFS pharmacy-related claim audit functions
  - Drug rebate services
  - Pharmacy rate setting
- Southeastrans – FFS nonemergency medical transportation (NEMT) broker
  - FFS NEMT provider network development
  - FFS NEMT member and provider support
  - FFS NEMT claim processing*
  - FFS NEMT transportation scheduling*

  * *Except for NEMT services that are exempt from the brokerage requirement.*
- MAXIMUS – Enrollment broker
  - HIP, Hoosier Care Connect, and Hoosier Healthwise member and provider support
  - Potential member program education
  - Counseling for health plan selection
  - MCE assignment for members who do not self-select an MCE
- Myers and Stauffer LC – Rate-setting contractor
  - Nonpharmacy rate setting
  - Long-term care audits

- Anthem, CareSource, Managed Health Services (MHS), and MDwise – IHCP-contracted MCEs for the HIP, Hoosier Care Connect, and Hoosier Healthwise programs (*See individual MCE websites for details of the programs and services they cover.*)
  - Utilization management and prior authorizations**
  - Establishing a provider network
  - Care management
  - Claim processing**
  - Member and provider support
  - Community outreach
  - Provider education

  ** *Note that, for certain services (such as dental or pharmacy), these functions may be handled by a subcontractor of the MCE.*

Indiana State Department of Health

The Indiana State Department of Health (ISDH) is responsible for certifying the following provider specialties:

- Nursing facilities
- Intermediate care facilities for individuals with intellectual disabilities (ICFs/IID)
- Pediatric nursing facilities
- Residential care facilities
- Home health agencies
- Hospitals (acute care, rehabilitation, and long-term acute care [LTAC])
- Ambulatory surgical centers (ASCs)
- Rehabilitation facilities
- Comprehensive outpatient rehabilitation facilities (CORFs)
- End-stage renal disease (ESRD) clinics
- Rural health clinics (RHCs)
- Radiology centers (freestanding and mobile x-ray facilities)
- Hospice facilities

In addition, the ISDH and the CMS certify providers for Clinical Laboratory Improvement Amendments (CLIA). CLIA certification is **required** for the following provider specialties (for other providers, CLIA certification may be required if applicable):

- Independent laboratories
- Mobile laboratories
- ESRD clinics

Providers may contact the ISDH at the following address or telephone number:

Indiana State Department of Health
2 N. Meridian St.
Indianapolis, IN 46204

(317) 233-1325 or **1-800-382-9480**

Provider Services

Being responsive to the needs of IHCP providers is a primary emphasis for the IHCP. Entities contracted with the FSSA perform parallel provider services functions for providers in their respective networks.

MCE Provider Services

Each MCE contracted for HIP, Hoosier Care Connect, or Hoosier Healthwise maintains a provider services unit to address the concerns and questions of providers serving members in their health plans. The *IHCP Quick Reference Guide*, available at in.gov/medicaid/providers includes contact information for these provider services units.

OptumRx Provider Services

OptumRx, the FFS pharmacy benefit manager (PBM), serves as the liaison between pharmacy providers and IHCP members for FFS programs and carved-out services. OptumRx maintains a provider services unit to address the concerns and questions of pharmacy providers rendering services to members in FFS programs, including the resolution of pharmacy-claim-processing issues. The *IHCP Quick Reference Guide*, available at in.gov/medicaid/providers includes contact information for the OptumRx Clinical and Technical Help Desk, where member and provider telephone inquiries should be directed.

DXC Provider Services

DXC, the IHCP fiscal agent, serves as the overall liaison between the provider and member communities for the IHCP. DXC performs provider services to address concerns and questions for providers conducting business with the IHCP, including the resolution of FFS nonpharmacy claim-processing issues. The following DXC business units perform provider services:

- Provider Enrollment Unit is responsible for provider enrollment, revalidation, and provider profile maintenance activities.
- Customer Assistance Unit is responsible for answering telephone inquiries.
- Written Correspondence Unit responds to inquiries submitted through the Portal and performs administrative reviews as directed by the FSSA.
- Provider Relations Unit functions as the educational arm of the IHCP.

> *Note: As of November 1, 2019, DXC will add a Prior Authorization Unit, which will assume responsibility for FFS nonpharmacy prior authorization and utilization management functions previously provided by CMCS.*

Provider Enrollment

The Provider Enrollment Unit performs the following key functions:

- Assesses provider eligibility through verification of licensure, certification, and insurance and approves documents required for enrollment. Enrollment requirements are based on provider type and specialty, and adhere to guidelines and rules set by federal and State regulations.
- Ensures that no enrolled provider is excluded from participation by the Office of the Inspector General (OIG), the CMS, or other federal or State agencies.
- Processes provider enrollment packets and profile maintenance forms.

- Deactivates enrolled providers that no longer meet State requirements for participation in the IHCP.
- Maintains provider files for all enrolled, denied, and terminated providers.

Enrollment analysts monitor enrollment activities from initial receipt of an enrollment application or provider profile update through final disposition.

IHCP enrollment applications and provider profile updates may be completed online using the Provider Healthcare Portal, accessible from the home page at in.gov/medicaid/providers. Printable enrollment packets and profile maintenance forms are available on the *Complete an IHCP Provider Enrollment Application* page at in.gov/medicaid/providers. For additional information about provider enrollment and profile maintenance, see the *Provider Enrollment* module or call Customer Assistance.

Customer Assistance

As the front line of communications with providers, Customer Assistance representatives quickly detect the impact of program policy and procedural changes through provider inquiries. Customer Assistance can be contacted toll-free at **1-800-457-4584**.

Live assistance is available 8 a.m. to 6 p.m. Eastern Time, Monday through Friday, excluding holidays. To maintain compliance with the HIPAA Provider Rule, Customer Assistance representatives cannot verify member eligibility.

Automated responses to provider inquiries are available 24 hours per day through the Interactive Voice Response (IVR) system. Automated IVR responses are available for such functions as verifying member eligibility, member benefit limits, and claim status.

> *Note: Providers can access pertinent member eligibility and claim status information online via the Portal or through the IVR system using a touch-tone telephone. Both systems provide access 24 hours a day, 7 days a week. Instructions for accessing these features are included in the Interactive Voice Response System and Provider Healthcare Portal modules.*
>
> *The 270/271 member eligibility and 276/277 claim status transactions are standardized, electronic data interchange (EDI) transactions. Data is sent and received in the same format for all providers. Additional information is available in the Electronic Data Interchange module and the IHCP Companion Guides at in.gov/medicaid/providers.*

To assist with timely processing of inquiries, providers should consider the following guidelines when contacting the Customer Assistance Unit:

- To verify member eligibility (for both FFS and managed care members), providers can inquire through the IVR system, Portal, or 270/271 health care eligibility benefit inquiry and response transaction.
- For general claim status inquiries of FFS claims, providers can check the weekly Remittance Advice (RA) or inquire through the IVR system, Portal, or 276/277 claim status request and response transaction.
- Providers should not inquire about the status of a specific claim until at least 30 business days after submission. This length of time is generally considered reasonable to process a claim.
- When contacting Customer Assistance to request information about an FFS claim, providers should be prepared with the following information:
  - Billing provider's 10-digit National Provider Identifier (NPI) or IHCP Provider ID
  - Full 9-digit ZIP Code (ZIP Code + 4) of the service location address
  - Facility name or practice name

  - Last four digits of the taxpayer identification number (TIN)
  - Member's name
  - Member's date of birth, Claim ID, or dates of service (including specification of the claim type, such as inpatient, outpatient, medical, dental, and so forth)
  - Amount billed

- If a provider speaks to a Customer Assistance representative, the provider should make a note of the date of the telephone call, the name of the representative who handled the call, and the contact tracking number (CTN). This information is helpful when a follow-up inquiry is necessary.
- Providers should contact the MCE with which the member is enrolled for inquiries about managed care claims.

Written Correspondence

The Written Correspondence Unit is another link between the provider community and the IHCP. Providers should contact the Written Correspondence Unit for assistance with researching complex FFS claim denials or when the provider experiences difficulty receiving claim payment. Additionally, providers can contact the Written Correspondence Unit to obtain other information, including member benefit limit information and clarification of the IHCP rules and regulations.

Providers are encouraged to provide comprehensive information in their correspondence, including a clearly stated reason for the inquiry. Providers should also include any of the following items that are applicable:

- Copies of submitted claim forms (or printouts of Portal claims) and any documentation that was attached
- Copies of RA statements

This information provides necessary details and is helpful in formulating an accurate and complete response to the provider. The more information provided about the history of a particular issue, the more easily an analyst can reach the resolution.

Inquiries and supporting documentation can be submitted electronically through the Portal using the Secure Correspondence feature. Each message is assigned a CTN, which can be used to track the status of the correspondence. When the Written Correspondence analyst resolves the inquiry, a notification email is sent to the provider with a link to the page on the Portal where the response can be reviewed. See the *Provider Healthcare Portal* module for details.

Written Correspondence analysts will respond in writing to the provider within 10 business days of receiving the written inquiry. Responses are assigned a CTN that is important for tracking and should be referred to in subsequent correspondence with the IHCP about the issue.

Providers should not use Written Correspondence to check claim status. Claim status can be determined by checking RA statements or inquiring through the Portal, IVR system, or 276/277 claim status request and response transaction.

Providers should not use the Written Correspondence Unit for claim submission, unless specifically directed to do so.

Requests for Paper Remittance Advice

Providers should access the Portal to view or download a Remittance Advice. However, providers can request a paper RA from the Written Correspondence Unit in the following ways:

- Submit the request as a secure correspondence message through the Portal.
- Email the request to inxixwrittencorr@dxc.com.

Requests for Administrative Review

The Written Correspondence Unit handles provider requests for administrative review of claim adjudication of all FFS nonpharmacy claims. See the *Claim Administrative Review and Appeals* module for more information.

Provider Relations

The Provider Relations Unit includes a team of regional field consultants that can assist providers via the telephone, emails, and on-site visits. Consultants also offer on-site training to encourage the provider community to use the Portal and *Health Insurance Portability and Accountability Act* (HIPAA)-compliant electronic transactions, and to recruit new providers for the IHCP. Specific region assignments and contact information are available on the *Provider Relations Field Consultants* page at in.gov/medicaid/providers or by calling Customer Assistance.

Provider Relations field consultants have the following key responsibilities:

- Work directly with the provider community to provide education and ensure program and claim-processing understanding.
- Create a stable, interpersonal relationship with the providers in their assigned geographical territory.
- Work closely with the financial managers, administrators, and business leaders of the provider community to educate about IHCP policies and objectives, assist with resolving provider issues, and conduct training seminars. To ensure a successful training seminar or on-site visit, it is recommended that the following information is provided to assist the field consultant in structuring the meeting or presentation to best meet the needs of the audience:
  - Provider community segment attending the seminar
  - Number of attendees
  - Time and location of the event
  - Issues to be addressed
  - Point of contact, in case additional information is needed prior to the event

The Provider Relations Unit also coordinates the broader provider education component of the IHCP. In conjunction with other program contractors, the unit works to develop and present educational sessions about all aspects of the IHCP. Scheduled workshops are offered twice throughout the year, as well as at an annual seminar. Providers may register for workshops using the Workshop Registration link on the *Provider Education Opportunities* page at in.gov/medicaid/providers. Also listed on that page are links to additional training resources, such as online webinars (*IHCP Live*) and various training documents for self-paced learning. Workshops and webinars are announced in IHCP provider bulletins and banner pages, provider association newsletters, and on the IHCP provider website at in.gov/medicaid/providers.

When contacting the Provider Relations field consultant, allow 24 hours for a response to the email or voicemail.

> *Note: The IHCP created the "IHCP Listens" email account (IHCPListens@fssa.in.gov) to solicit input from the provider community about the following:*
>
> - *Feedback on workshops, webinars, and other presentations made on behalf of the IHCP*
> - *Ideas for future workshops and presentations*
> - *Requests for clarification of policies and programs (in future workshops or written communication)*

Provider Resources and Contact Information

Table 2 is designed to provide a quick reference for providers with questions about claims or programs, or in need of clarification on a specific topic.

Table 2 – Provider Resources

Provider Resource	How to Access Resource	When to Use Resource
IHCP Bulletins and Banner Pages	View or download from the *News, Bulletins, and Banner Pages* page at in.gov/medicaid/providers	*Bulletins* provide official notice of new and revised policies, program changes, and information about special initiatives. *Banner pages* provide official notice of changes to claim processing, billing guidance, as well as details about provider education opportunities and program reminders. Providers are required to stay abreast of IHCP notices. These IHCP publications are archived on the website for historical purposes. Providers are cautioned not to rely on dated publications. The most current information about a topic can be found either in the posted provider reference module or in publications issued after the effective date of the module.
IHCP Provider Reference Modules	View or download from the *IHCP Provider Reference Modules* page at in.gov/medicaid/providers	Providers can refer to the *IHCP Provider Reference Modules* as a resource for medical coverage, prior authorization request procedures, billing guidance, claim submission and processing information, reimbursement policy, and other related topics. These modules include links to billing-related code tables and answers to billing and other procedural questions. Updates to policies and procedures are announced in IHCP banner pages and bulletins and added to the published reference modules at regular intervals.

Provider Resource	How to Access Resource	When to Use Resource
IHCP provider website	in.gov/medicaid/providers	Providers can access the website to obtain program information, such as the following: • *IHCP Banner Pages* • *IHCP Bulletins* • News and announcements • *IHCP Provider Reference Modules* • Fee schedules (professional and outpatient) • Code tables • Provider enrollment and profile maintenance packets • Program descriptions • Contact information • Provider education opportunities • Forms, including prior authorization request forms • Provider Healthcare Portal • EDI information, including *IHCP Companion Guides* for HIPAA version 5010
Provider Healthcare Portal	portal.indianamedicaid.com, accessible from the home page at in.gov/medicaid/providers	New providers can enroll in the IHCP through the Portal. Enrolled providers can become registered Portal users to access functions such as the following: • Update provider information on file • Verify member eligibility and check benefit limits • File claims and check claim status (FFS, nonpharmacy claims only) • Submit PA requests and check PA status (FFS, nonpharmacy PA only)
Customer Assistance telephone line	Toll-free at **1-800-457-4584** Automated assistance is available 24 hours a day through the Interactive Voice Response (IVR) system. Live assistance available 8 a.m. – 6 p.m. Eastern Time Monday through Friday, excluding holidays	The Customer Assistance line represents the primary access point for telephone inquiries about IHCP provider enrollment, third-party liability, claim submission and processing, EDI trading partner and Provider Healthcare Portal technical assistance, policy, and covered services. The following functions are available through the IVR system: • Verify member eligibility and check benefit limits • Check claim status (fee-for-service, nonpharmacy claims only) • Check PA status (fee-for-service, nonpharmacy PA only)

Provider Resource	How to Access Resource	When to Use Resource
Written Correspondence	Contact DXC via secure correspondence on the Provider Healthcare Portal	Providers can contact the Written Correspondence Unit to address specific questions about the IHCP, to get claim-specific assistance (such as researching complex claim denials, member benefit limits, or problems receiving payment), to request a paper RA, or to request administrative review of a claim. Providers should not submit claims for processing to the Written Correspondence Unit unless specifically directed to do so. The Written Correspondence Unit forwards medical policy inquiries to the OMPP.
Provider Relations field consultants	Field consultant assignments and voice mail extensions are available on the *Provider Relations Field Consultants* page at in.gov/medicaid/providers or from Customer Assistance	Providers can contact field consultants for explanations of IHCP policies and objectives, assistance in resolving issues, and setting up training seminars and on-site visits.
IHCP Quick Reference Guide	View or download from in.gov/medicaid/providers	Refer to this guide for telephone numbers, addresses, and online resources for various entities that support the IHCP.

Avenues of Resolution

The following tools are available to assist providers in resolving concerns related to various issues.

IHCP Policy, Including Medical Coverage Policy

For concerns related to IHCP coverage or policy, submit a *Policy Consideration Request Form* by email to Policyconsideration@fssa.in.gov. The form is available on the *Forms* page at in.gov/medicaid/providers.

Reimbursement

To resolve problems or disagreements related to the denial or payment of FFS claims, see the *Claim Administrative Review and Appeals* module.

To resolve problems or disagreements related to managed care claims, see the grievance procedures established by the individual MCE.

Prior Authorization

To resolve problems associated with FFS prior authorizations, see the *Prior Authorization* module.

To resolve problems associated with managed care prior authorization, see the grievance procedures established by the individual MCE.

Provider or Member Fraud

To report Medicaid fraud or abuse, see the *IHCP Quick Reference Guide*, available at in.gov/medicaid/providers for contact information. More information about provider or member fraud and abuse is available in the *Provider and Member Utilization Review* module.

Member Eligibility Determination

To resolve member eligibility problems involving caseworkers or supervisors, call the DFR toll-free telephone number at **1-800-403-0864** or contact the local DFR office. See the directory of local DFR offices on the FSSA website at in.gov/fssa.

The telephone number for the DFR also serves as the fax number for the FSSA Document Center. The address for the Document Center is:

FSSA Document Center
P.O. Box 1810
Marion, IN 46952

If a director does not respond to the complaint to the provider's satisfaction, the provider can write a letter providing facts to the DFR deputy director at the following address:

MS03
Deputy Director
Division of Family Resources
Family and Social Services Administration
402 W. Washington St., Room W392
Indianapolis, IN 46204

Providers should specify in the letter their attempts made to resolve the problem.

Civil Rights Requirements

The IHCP does not discriminate on the basis of race, color, national origin, sex, age, or disability in compliance with federal requirements set forth in:

- *Section 1557 of the Affordable Care Act*
- *Title VI of the Civil Rights Act of 1964*
- *Section 504 of the Rehabilitation Act of 1973*
- *Age Discrimination Act of 1975*
- *Omnibus Budget Reconciliation Act (OBRA) of 1981, where applicable*

If a provider receives a complaint of an alleged violation of the *Civil Rights Act*, the provider must advise the FSSA of the complaint. Within 10 working days from the date the provider receives notification of a civil rights violation complaint, the provider must send a copy of the complaint to the following address:

MS15
Kelly Flynn
Civil Rights Plan Coordinator
Office of Medicaid Policy and Planning
402 W. Washington St., Room W374
Indianapolis, IN 46204

Federal laws and regulations require similar compliance from all recipients of federal funds. Federal rules require such entities, including IHCP providers, to demonstrate such compliance by taking the following actions:

- All IHCP providers must prominently post notices that specify the following information:
  - The provider complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age, or disability
  - The provider makes available free aids and services to people with disabilities to communicate effectively with the provider, including qualified interpreters, written information in other formats and free language services to people whose primary language is not English
  - How to obtain the aids and services referenced previously
  - The name and contact information of the provider's civil rights coordinator who handles grievances (if the provider employs 15 or more individuals)
  - The availability of a grievance procedure as well as how to file a grievance
  - How to file an Office for Civil Rights (OCR) complaint

  A sample posting is available at the Department of Health and Human Services (HHS) website at hhs.gov for your reference. The IHCP has developed a sample posting specific to the state of Indiana, as shown on page 1 of Figure 1.

- All IHCP providers must include taglines in published materials to alert individuals with limited English proficiency (LEP) to the availability of language assistance services. Major patient publications are required to include taglines translated into at least the top 15 languages spoken by individuals with LEP in the state. Lesser patient publications are required to include taglines for the top two languages spoken. Translated resources for nondiscrimination notices and taglines are available in these and many languages at the HHS website at hhs.gov. The sample nondiscrimination posting includes taglines with the top 16 languages spoken in Indiana, as shown on page 2 of Figure 1.

Providers must comply with federal law with regard to the *Patient Self-Determination Act* contained in the *OBRA of 1990*. This law requires that providers advise adult patients about the patient's right to determine treatment before they can no longer make healthcare decisions for themselves. The patient can express their choice in an *advance directive*.

Figure 1 – Sample Nondiscrimination Posting (Page 1 of 2)

Discrimination is Against the Law

[Paste provider identifier label here]

- Complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- Does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
- Provides free aids and services to people with disabilities to communicate effectively with us.
- Provides free language services to people whose primary language is not English.

If you need these services, help is available. [Paste contact label here]

If you believe we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email. [Paste contact label here]

If you need help filing a grievance help is available. [Paste contact label here]

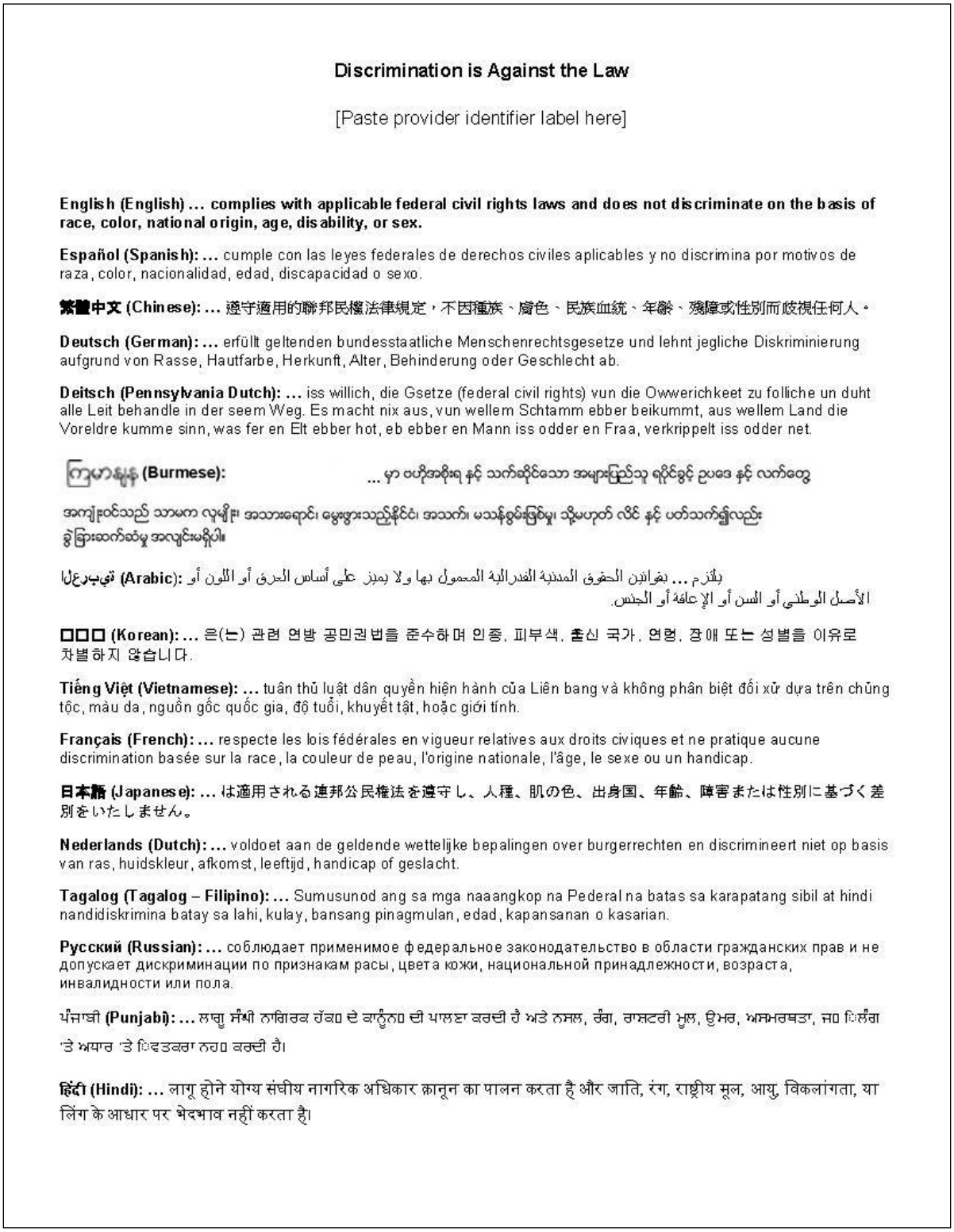
You can also file a civil rights complaint with the Indiana Civil Rights Commission (ICRC) by calling **1-800-628-2909 or filing electronically at** in.gov/icrc/.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or telephone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019; 1-800-537-7697 (TDD)

Figure 1 – Sample Nondiscrimination Posting (Page 2 of 2)



Discrimination is Against the Law

[Paste provider identifier label here]

English (English) … complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish): … cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

繁體中文 (Chinese): … 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Deutsch (German): … erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Deitsch (Pennsylvania Dutch): … iss willich, die Gsetze (federal civil rights) vun die Owwerichkeet zu folliche un duht alle Leit behandle in der seem Weg. Es macht nix aus, vun wellem Schtamm ebber beikummt, aus wellem Land die Voreldre kumme sinn, was fer en Elt ebber hot, eb ebber en Mann iss odder en Fraa, verkrippelt iss odder net.

ကရင်ဘာသာစကား (Burmese): … မှာ ဗဟိုအစိုးရ နှင့် သက်ဆိုင်သော အများပြည်သူ ရပိုင်ခွင့် ဥပဒေ နှင့် လက်တွေ့ အကျင့်ဝင်သည် သာမက လူမျိုး၊ အသားရောင်၊ မွေးဖွားသည့်နိုင်ငံ၊ အသက်၊ မသန်စွမ်းဖြစ်မှု၊ သို့မဟုတ် လိင် နှင့် ပတ်သက်၍လည်း ခွဲခြားဆက်ဆံမှု အလျင်းမရှိပါ။

العربية (Arabic): … يلتزم بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.

□□□ (Korean): … 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Tiếng Việt (Vietnamese): … tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Français (French): … respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

日本語 (Japanese): … は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害または性別に基づく差別をいたしません。

Nederlands (Dutch): … voldoet aan de geldende wettelijke bepalingen over burgerrechten en discrimineert niet op basis van ras, huidskleur, afkomst, leeftijd, handicap of geslacht.

Tagalog (Tagalog – Filipino): … Sumusunod ang sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

Русский (Russian): … соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

ਪੰਜਾਬੀ (Punjabi): … ਲਾਗੂ ਸੰਘੀ ਨਾਗਰਿਕ ਹੱਕ□ ਦੇ ਕਾਨੂੰਨ□ ਦੀ ਪਾਲਣਾ ਕਰਦੀ ਹੈ ਅਤੇ ਨਸਲ, ਰੰਗ, ਰਾਸ਼ਟਰੀ ਮੂਲ, ਉਮਰ, ਅਸਮਰਥਤਾ, ਜ□ ਿਲੰਗ 'ਤੇ ਅਧਾਰ 'ਤੇ ਿਵਤਕਰਾ ਨਹ□ ਕਰਦੀ ਹੈ।

हिंदी (Hindi): … लागू होने योग्य संघीय नागरिक अधिकार क़ानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, या लिंग के आधार पर भेदभाव नहीं करता है।